TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DARREN D. GORE, PA

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-15-2390-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
APRIL 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "*63042/AS/59, 63030/AS/59, 63056/AS/59 are all for the purpose of decompression and not bundled to 22633/AS. 63042/AS/59 is for –Redo hemilaminectomy to right at L5-S1, 63030/AS/59 is for –hemilaminectomy to left at L5-S1, and 63056/AS/59 is for –far lateral decompression to the right at L5-S1 All done in addition to fusion hence not bundle and done at separate locations hence reimbursement justified for assistance*."

Amount in Dispute: $1,023.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Carrier is maintaining their position that the additional $1023.77 requested is not owed to the requestor."

Response Submitted by: AIG Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 8, 2014	CPT Code 63030-AS-59 Spinal Surgery	$264.60	$0.00
	CPT Code 63056-AS-59 Spinal Surgery	$404.14	$0.00
	CPT Code 63042-AS-59 Spinal Surgery	$355.03	$0.00
TOTAL		$1,023.77	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - Per NCCI, the procedure code is denied, based on standard of medical, surgical practice.
   - B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.
   - W3-Request for reconsideration.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
   - Workers' compensation medical treatment guideline adjustment.
   - The number of units billed for this procedure code exceeds the reasonable number usually provided in a given setting, as defined within the Medically Unlikely Edits (MUEs) which is published and maintained by the Centers for Medicare and Medicaid Services. The provider's charge was granted an allowance up to the MUE value.
   - No additional reimbursement allowed after review of appeal/reconsideration.
   - Duplicate claim/service.
   - Claim/service lacks information which is needed for adjudication.

Issues

1. Is the benefit for HCPCS code 63030 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement?
2. Is the benefit for HCPCS code 63056 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement?
3. Is the benefit for HCPCS code 63042 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of the respondent denied reimbursement for CPT code 63030 based upon reason code "97."

   On the disputed date of service, the requestor billed codes 62350-AS, 63030-AS-59, 63056-AS-59, 63042-AS-59, 22851-AS, 22840-AS, 22633-AS, 20936-AS, and 20930-AS.

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 63030 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar."

   CPT code 22633 is defined as "Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar."

   28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Per CCI edits, CPT code 63030 is a component of 22633, effective January 1, 2012. A modifier is allowed to differentiate the service. The requestor appended modifiers "AS-Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery," and "59-Distinct Procedural Service" to code 63030.

Modifier “59” is defined as “Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.”

The Operative Report indicates that claimant underwent “Redo hemilaminectomy to right at L5-S1, hemilaminectomy to left at L5-S1, and far lateral decompression to the right at L5-S1 for decompression and formainal disk herniation and compression on the L5 nerve root. TLIF with Aesculap PEEK cage, L5-S1 with autorgraft and allograft with nonsegmental instrumentation, L5-S1. Epidural catheter and instrumentation.”

A review of the submitted reports does not support a “different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.” The Division finds that the requestor has not supported the use of modifier “59.” As a result, reimbursement is not recommended.

2. According to the explanation of the respondent denied reimbursement for CPT code 63056 based upon reason code “97.”

   CPT code 63056 is defined as “Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc).”

   Per CCI edits, CPT code 63056 is a component of 22633, effective January 1, 2012. A modifier is allowed to differentiate the service. The requestor appended modifiers “AS-Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery,” and “59-Distinct Procedural Service” to code 63056.

   A review of the submitted reports does not support a “different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.” The Division finds that the requestor has not supported the use of modifier “59.” As a result, reimbursement is not recommended.

3. According to the explanation of the respondent denied reimbursement for CPT code 63042 based upon reason code “97.”

   CPT code 63042 is defined as “Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar.”

   Per CCI edits, CPT code 63042 is a component of 22633, effective January 1, 2012. A modifier is allowed to differentiate the service. The requestor appended modifiers “AS-Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery,” and “59-Distinct Procedural Service” to code 63042.

   A review of the submitted reports does not support a “different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.” The Division finds that the requestor has not supported the use of modifier “59.” As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		06/25/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.